

## PO 2: Resource Stewardship

The organization has the capability to manage its resources effectively to meet the health care needs of its patients.

### Intent

The organization provides resources to patients and providers to aid with clinical decision making and monitors practice patterns to ensure that needed care is delivered.

### Element A: Decision Support

1.70 points

The organization adopts evidence-based guidelines and disseminates decision support tools to participating providers for the following:

1. At least one important chronic condition
2. At least one high-risk or complex condition
3. At least one condition related to unhealthy behaviors or mental health or substance abuse.

### Scoring

100%	75%	50%	25%	0%
The organization meets all 3 factors	The organization meets 2 factors	The organization meets 1 factor	No scoring option	The organization meets no factors

**Data source** Documented process, Materials

**Scope of review** NCQA scores this element once for the organization.

**Look-back period** *For Initial Surveys:* 6 months prior to survey  
*For Renewal Surveys:* 24 months prior to survey

**Explanation** The organization establishes implements and periodically updates evidence-based guidelines and provides tools and resources at the point of care to promote the delivery of evidence-based medicine.

**Evidence-based guidelines** are clinical practice guidelines known to be effective in improving health outcomes. Effectiveness of guidelines is determined by scientific evidence; or by professional standards in the absence of scientific evidence; or by expert opinion in the absence of professional standards. The organization adopts clinical practice guidelines, translates them into meaningful tools and promotes them to practitioners in an effort to improve health care quality and reduce unnecessary variation in care. Clinical practice guidelines may address chronic conditions or other important conditions for which the organization is experiencing variances from “best care” practices.

**Decision support tools** include algorithms practitioners can use to develop new processes for patient care or create treatment plans and flow sheets to document patient progress, or that can be embedded in electronic health records (EHR).

**Chronic conditions** are diseases or conditions that are usually of slow progress and long continuance and require ongoing care (e.g., hypertension, asthma, diabetes).

**High-risk or complex conditions** are identified by the organization. They may include the following conditions or requirements, or a combination thereof.

- High level of resource use (e.g., visits, medication, treatment or other measures of cost)
- Frequent visits for urgent or emergent care (i.e., two or more visits in the last six months)
- Frequent hospitalizations (i.e., two or more in the last year)
- Multiple comorbidities, including mental health
- Noncompliance with prescribed treatment/medications
- Terminal illness
- Psychosocial status, lack of social or financial support that impedes ability for care
- Advanced age, with frailty
- Multiple risk factors.

**Factor 3:** At least one identified condition must be related to unhealthy behaviors (e.g., obesity, smoking), substance abuse (e.g., illegal drug use, prescription drug addiction, alcoholism) or a mental health issue (e.g., depression, anxiety, bipolar disorder, ADHD, ADD, dementia, Alzheimer's).

### **Documentation**

NCQA reviews:

- The list of three condition types outlined in factors 1–3.
- The name and source of evidence-based guidelines or clinical pathways for each condition.
- The organization's process for adopting clinical practice guidelines and disseminating decision support tools based on the guidelines to participating providers. The process must include its plans for periodically reviewing and updating the guidelines.
- Examples of decision support tools provided to participating providers for each condition. These may include flow sheets or templates based on condition-specific guidelines or electronic system organizers (e.g., registry, EHR, other system).

Evidence-based guidelines and the process for adopting and periodically reviewing and updating guidelines must be in effect for at least 6 months prior to an Initial Survey. If the guidelines and process have been in place for longer than 12 months, the organization must show evidence that they were reviewed within the 12 months prior to survey.

### **Examples**

None.

**Element B: Patient Decision Aids****1.70 points**

The organization makes patient decision aids available to participating providers to promote patient engagement.

Scoring	100%	75%	50%	25%	0%
	The organization has a process	No scoring option	No scoring option	No scoring option	The organization does not have a process

**Data source** Documented process, Materials

**Scope of review** NCQA scores this element once for the organization.

**Look-back period** *For Initial Surveys:* 6 months prior to survey  
*For Renewal Surveys:* 24 months prior to survey

**Explanation** Research indicates that patients and their physicians are more satisfied with the care choice when patients are engaged and receive information about their care. Patient **decision aids** are tools that help patients become involved in decisions about their care by providing them with information about treatment options and outcomes. They are designed to complement counseling from a health practitioner, not replace it. Decision aids may focus on preference-sensitive conditions, chronic care management or lifestyle changes to encourage patient commitment to self-care and treatment regimens.

**Documentation**

NCQA reviews the organization's process for making decision aids available to participating providers and examples of actual decision aids that are available. The organization must describe its process to adopt, implement and periodically update its decision aids.

The process must be in effect for at least 6 months prior to an Initial Survey. If the process has been in place for longer than 12 months, the organization must show evidence that it was reviewed within the 12 months prior to survey.

**Examples** None.

**Element C: Monitoring Practice Patterns****1.70 points**

The organization identifies and monitors:

1. At least three practice patterns for excessive utilization, appropriateness of care or activities that waste resources
2. Complaints and the results of patient satisfaction surveys to determine if patients feel they are receiving needed care.

Scoring	100%	75%	50%	25%	0%
	The organization meets both factors	No scoring option	The organization meets 1 factor	No scoring option	The organization does not meet either factor

**Data source** Documented process, Reports, Materials

**Scope of review** NCQA scores this element once for the organization.

**Look-back period** *For Initial Surveys:* Within the 12 months prior to survey  
*For Renewal Surveys:* 24 months prior to survey

**Explanation Practice patterns**

**Excessive utilization** (i.e., overutilization) is characterized by the use of more costly specialists or higher volumes of services such as office visits, hospitalizations, tests, procedures and prescriptions than is appropriate.

**Appropriate care** is care that either:

- Produces substantially more health benefit than harm and is preferred over other available options, **or**
- Produces more good than harm by a sufficiently wide margin to justify the use.

**Waste** is any intervention that has no possible benefit for the patient or in which the potential risk to the patient is greater than the potential benefit.

The organization monitors for clinically and financially important practice pattern variations, including those that indicate excessive utilization, inappropriate care or activities that waste resources. Monitoring activities might include emergency room utilization, facility type and facility level use, clinical appropriateness (e.g., was the high-tech imaging study or the CABG clinically necessary and appropriate, given the clinical presentation?), clinical complications, or readmission. The organization may change the care patterns it monitors over time as needed to meet organizational objectives.

**Patient experience**

Organizations should consider the impact of initiatives to reduce waste and increase the delivery of appropriate care on patient experience. Reviewing patient experience surveys, complaints and appeals can help organizations determine whether patients believe they are receiving needed care.

**Complaints** are oral or written expressions of dissatisfaction. The organization may use other terms for this level of interaction with patients, such as *grievance* or *concern*. NCQA refers to patients' initial expression of concern as "complaints."

**Documentation**

NCQA reviews the results of the organization's monitoring activities. Documentation should include:

- The process used to identify care patterns to be monitored, which includes a description of how the organization ensures its monitoring activities are relevant to the population.
- A description of the care patterns or conditions the organization is monitoring. Monitoring activities must go beyond measuring underuse (e.g., adherence to guidelines).
- A description of participating providers included in monitoring activities.
- A description and frequency of the reports sent to participating providers.
- Specialty type for physicians included in activities (e.g., primary care, cardiology).
- Results detailing variations in care patterns, compared with goals, benchmarks or peers.
- Results of patient experience surveys and complaints analysis (for factor 2).

**Examples** None.

**Element D: Provider Detailing****1.70 points**

The organization:

1. Provides performance reports to participating providers that detail variation in care patterns
2. Provides training and education on reducing variances to clinicians.

Scoring	100%	75%	50%	25%	0%
	The organization meets both factors	No scoring option	The organization meets 1 factor	No scoring option	The organization does not meet either factor

**Data source** Documented process, Reports, Materials

**Scope of review** NCQA scores this element once for the organization.

**Look-back period** *For Initial Surveys:*

- Factor 1: Within the 12 months prior to survey
- Factor 2: 6 months prior to survey

*For Renewal Surveys:* 24 months prior to survey

**Explanation** The organization provides reports to participating providers when care patterns vary from expected or "best care" and provides training and education to assist clinicians in acquiring needed information or skills to address the variance.

**Documentation**

Factor 1: NCQA reviews an example of an actual report provided to participating providers within the past 12 months. The report must highlight opportunities to improve performance. Opportunities may be highlighted by providing comparison with goals, benchmarks or peers or by using a system developed by the organization.

Factor 2: NCQA reviews the organization's documented process for making training and education available to participating providers, and reviews examples of materials the organization provides. The documented process must be in effect for at least 6 months prior to an Initial Survey. If the process has been in place for longer than 12 months, the organization must show evidence that it was reviewed within the 12 months prior to survey.

**Examples****Practice pattern variation reports**

The organization provides reports to participating providers that detail:

- Admissions that could have been avoided by appropriate outpatient care for conditions like asthma or diabetes
- Readmissions within 30 days of hospital discharge
- Nonurgent use of emergency departments
- Use of high-tech diagnostic imaging such as CT, PET and MRI
- Adherence to guidelines (e.g., report showing the percentage of diabetic measures checked during an encounter with a physician).

## PO 3: Payment Arrangements

The ACO's payment arrangements align provider incentives and promote the delivery of efficient and effective care.

### Intent

The ACO arranges payment for participating providers and works with payers to determine reimbursement.

### Element A: Payment Arrangements

1.75 points

If the organization has performance-based compensation, it:

1. Bases at least a portion of the compensation provided to participating providers on the performance of the ACO as a whole, using clinical quality, cost and patient experience indicators
2. Informs patients about performance-based payment arrangements with participating providers
3. Has a process to monitor utilization patterns for inappropriate restrictions on care that may unintentionally arise from payment arrangements.

### Scoring

100%	75%	50%	25%	0%
The organization meets all 3 factors	The organization meets 2 factors	The organization meets 1 factor	No scoring option	The organization meets no factors

### Data source

Documented process, Materials

### Scope of review

NCQA scores this element once for the organization.

### Look-back period

*For Initial Surveys:* 6 months prior to survey

*For Renewal Surveys:* 24 months prior to survey

### Explanation

To align incentives between the organization and its practitioners, the ACO should have a payment mechanism that rewards participating providers based on the performance of the overall organization. The organization determines which providers it includes in its performance-based payment program. While the organization may benefit from having a performance-based payment program that includes all participating providers, it is not required to meet factor 1.

### Documentation

Factor 1: NCQA reviews the organization's documented process for how it compensates participating providers. The process must include information about which providers receive performance-based payments; whether quality, cost and satisfaction indicators are part of the compensation structure; and how much of the participating providers' total compensation is performance based.

Factor 2: The organization informs patients about performance-based payment incentives it offers participating providers. Transparency in payment arrangements can reassure consumers that the organization does not offer clinicians an incentive to withhold needed care. NCQA reviews the organization's documented process for





informing patients about performance-based payment arrangements, and reviews an example of patient materials. The documented process must state how the organization makes the information available to patients, and how frequently.

Factor 3: The organization has a process to evaluate utilization patterns to determine if payment arrangements are unintentionally promoting restrictions on care. The process must include:

- How the organization identifies services that are at risk for inappropriate reductions
- How long the organization tracks targeted services and frequency of reports
- Actions it takes if it finds inappropriate reductions in care.

Documented processes must be in effect for at least 6 months prior to and Initial Survey. If the processes have been in place for longer than 12 months, the organization must show evidence that they were reviewed within the 12 months prior to survey.

#### **Exception**

This element is NA if the organization has no performance-based compensation arrangements with participating providers. The organization must attest that none of its participating providers receives performance-based compensation from the organization.

#### **Examples**

None.

**Element B : Working With Payers****0.75 points**

The organization:

1. Describes how it works with payers to determine reimbursement for services
2. Describes risk adjustment methodology used to determine required reimbursement-levels
3. Has a process to conduct ongoing monitoring of services rendered and the cost for those services, compared to the revenue received, if applicable
4. Has stop-loss or reinsurance provisions, if applicable.

Scoring	100%	75%	50%	20%	0%
	The organization meets all 4 factors	The organization meets 3 factors	The organization meets 2 factors	No scoring option	The organization meets 0-1 factors

**Data source** Documented process, Materials

**Scope of review** NCQA scores this element once for the organization.

**Look-back period** *For Initial Surveys:* 6 months prior to survey  
*For Renewal Surveys:* 24 months prior to survey

**Explanation** The organization describes how it works with payers.

**Documentation**

NCQA reviews the organization's description of:

- How it works with payers to determine reimbursement for services.
- The risk adjustment methodology used, if any.

The process for monitoring reimbursement levels to determine if payment is sufficient to cover the care provided to patients. The documented process must be in effect for at least 6 months prior to an Initial Survey. If the documented process was in place for longer than 12 months the organization must show evidence that it was reviewed within the 12 months prior to survey

- Arrangements for stop loss or re-insurance. Organizations that are partially or fully at risk for patient care may attest that they have sufficient stop-loss or reinsurance provisions.

**Exceptions**

Factors 3 and 4 are NA if the organization does not take full or partial financial risk.

**Examples** None.

**Element C: Payer Contracts****1.75 point**

Contracts with payers specifically address:

1. The payment method used to reimburse for care
2. Payment turnaround times
3. The covered population
4. Service categories included
5. Services covered, as well as the scope and duration of treatment covered
6. The attribution model used to assign patients
7. Policies governing payer use of performance data.

Scoring	100%	75%	50%	25%	0%
	The organization meets all 7 factors	The organization meets 5-6 factors, including factor 7	The organization meets 3-4 factors, including factor 7	No scoring option	The organization meets 0-2 factors, or does not meet factor 7

**Data source** Materials

**Scope of review** Scoring of this element is based on a sample of three contracts executed within the previous two years,

**Look-back period** *For Initial and Renewal Surveys:* Within the 24-months prior to survey

**Explanation** **Factor 7 is a critical factor and must be met for practices to receive a score on the element.**

Contracts between the payers and the organization may vary according to the needs of the parties. The contracts should address the following.

- **Payment method.** The organization identifies the method payers use to reimburse for care. If the organization uses different payment methods to reimburse for different types of care, it documents this in the contract.
- **Payment timelines.** The contract specifies payment turnaround times.
- **Population covered.** The services required by patients will be influenced by demographic factors such as age, gender and socioeconomic status. Defining the population to be served by the organization will allow it to plan for needed care and determine adequate reimbursement levels. The organization must specify the populations covered under the contract. The defined population may include a product line (e.g., commercial, Medicare, Medicaid) or include a subset of members, as described by the payer.
- **Service categories.** Clearly defining the responsibilities of the organization allows it to proactively plan for patient care needs. Contracts must include the types of care covered (e.g., inpatient, outpatient).
- **Services covered, scope and duration.** The contract includes a description of the services included, scope of the services, and when coverage begins and ends (if applicable).
- **Attribution model.** The contract includes a description of the methodology used to assign patients to the ACO.

- **Payer performance data use.** The contract describes how payers are allowed to use the performance data of participating providers. The contract should not restrict or limit payer's efforts to use the data for quality improvement or reporting to consumers. To promote sound measurement and reporting practices, organizations may require payers to follow principles such as those outlined by the Patient Charter for Physician Performance Measurement, Reporting and Tiering Programs.

Factor 7 is met if the organization does not restrict the use of performance data by payers. The organization must note that this is the case in response to NCQA for this element. This factor does NOT require the contract to have an affirmative statement about the lack of restrictions.

### Documentation

NCQA reviews up to three contracts with payers, selected by the organization, executed within the previous 24 months to determine whether they contain the required content.

### Examples

- Payment methods may include fee-for-service (FFS), capitation and shared savings arrangements. The contract may specify that global capitation is used for maternity care and that FFS payments with shared savings provisions are used for other types of care.
- The contract, or the addendum to the contract, specifies that the following services for breast cancer treatment are covered.
  - Diagnostic mammogram examinations
  - Routine mammogram examinations after the maximum benefits under the routine physical exam provision have been paid
  - Mastectomy and lymph node dissection; complications from mastectomy, including lymphedema
  - Reconstructive surgery performed to restore and achieve symmetry following a medically necessary mastectomy
  - Breast prostheses following mastectomy.